Exeter Hospital
5 Alumni Drive
Exeter, NH 03833
(603) 778-7311

**EM CLINICAL REPORT**

Name: IRISH,JOHNATHON S
DOB:
PCP: MD NONE
Attending Dr:
Location: ED Room #:
Report Start Date/Time: 05/12/18 2102

MR #: M000413777
Account #: V00002750952
Admit Date:

Report #: 0512-0253

*****NOTE: This report is Signed

## H & P

**Provider contact time:** 20:41
**Subjective & Objective Data:**
COUGH, CONGESTION X 24 HOURS. TOOK ZITHROMAX FROM PREVIOUS SCRIPT YESTERDAY AND TODAY WITH NO EFFECT. USING HOME REMEDIES. COUGHING UP YELLOW MUCUS.

## Recent Travel History

**Recent Travel History:** No
**Hx Exposed to Comm. Disease:** No
**HPI/ROS**
31 -year-old male with history of asthma presents for evaluation of cough and congestion. Patient reports this started yesterday. Initially he had some congestion and clear nasal discharge, subsequently he has had some yellow and green nasal discharge and sputum production. He has had a sore throat, subjective fever, cough and dyspnea on exertion. He does report a history of childhood asthma. He did try using albuterol at home prior to arrival. He has had normal oral intake. No nausea or vomiting, no abdominal pain, no rash.
I have reviewed the nurses history for past medical history and social history.

REVIEW OF SYSTEMS:
5 systems were reviewed as negative, except for what is documented in the HPI.

## Past Medical/Surgical History

**Past Medical History(PMH):** Denies: Cardiac Disorders, Communicable Disease, Endocrine Disorders, Extended Spectrum Beta, GI Disorders, Genitourinary Disorder, HEENT Problems, MRSA, Musculoskeletal Disorder, Neurological Disorders, Other Medical History, Psychiatric Problems, Reproductive Disorders, Tetanus (2004), VRE
**Allergies:**
**Coded Allergies:**
Bee Pollen (Unverified Allergy, Mild, HIVES, 8/30/16)
Codeine (Unverified Allergy, Unknown, ANAPHYLATIC REACTION, 8/30/16)
Meperidine (Unverified Allergy, Unknown, ANAPHYLATIC REACTION, 8/30/16)
**Home Medication List:**
**Active Scripts**
**Oxycodone W/ Acetaminophen** (Percocet 5-325 mg) 1 Tab Tab, 1-2 TABS PO Q4-6H PRN Y, #20 TAB
FOR PAIN
Prov:ANDRADA MD,ELIZABETH C 8/30/16
**Ibuprofen** (Motrin) 800 Mg Tab, 1 TAB PO Q8H PRN Y, #20 TAB
Prov:ANDRADA MD,ELIZABETH C 8/30/16

## Social History

**Smoking Status:** Former Smoker
**Hx Tobacco Use:** No (QUIT 1 YR AGO)

EXETER HOSPITAL
Exeter, New Hampshire

EMERGENCY DEPARTMENT NOTE

RE: IRISH, JONATHAN
DATE OF SERVICE: 06/09/95

HISTORY OF PRESENT ILLNESS: This 8 year old male presents to the Emergency Room after an injury to his left eye. The patient was struck in the left eye by a large rock that was apparently thrown from a riding lawnmower. The rock apparently hit a tire on another vehicle and then struck the boy in the eye. He was knocked to the ground, but apparently did not lose consciousness. There was one episode of vomiting en route to the hospital.

ALLERGIES: DEMEROL.

PAST MEDICAL HISTORY: There is a history of a seizure disorder as well as asthma.

CURRENT MEDICATIONS: Depakote, Proventil and Vanceril.

PHYSICAL EXAMINATION: Pulse: 96. Respirations: 20. Blood Pressure: 124/76. Child is up to date on his tetanus immunization. This is an 8 year old child, the left eye has been previously bandaged. There is blood on the face. He is able to open his right eye and is alert and cooperative. He does appear to be in mild to moderate distress and is appropriately anxious.
HEENT: head is atraumatic, except for the area around the left eye. Speech is fluent.
NECK: nontender with full range of motion, flexion, extension, lateral rotation.
BACK: nontender.
CHEST: nontender.
LUNGS: breath sounds equal bilaterally, no rales, rhonchi or wheezes heard.
CARDIOVASCULAR: regular rhythm, no murmur.
ABDOMEN: soft.
EXTREMITIES: patient moves all four extremities equally and well.

LEFT EYE: the dressing was removed carefully in a sterile technique, and examination revealed a large left periorbital hematoma. There were two lacerations noted to the left upper lid. The lid margins were separated carefully but I was not able to visualize anything other than clotted blood. There was also a small amount of active bleeding present. These efforts were terminated due to the amount of swelling and the obvious significant trauma by exam and by history. IV was established, and 500 mg of Ancef were ordered for the patient. He subsequently vomited in the Emergency Room and was given 5 mg of Phenergan. CAT scan of the head and left orbit was arranged on a STAT basis.

**EXETER HOSPITAL, INC.**
EXETER, NH 03833

EMERGENCY DEPARTMENT NOTE

RE: IRISH, JONATHAN S.
DATE OF SERVICE: 08/15/99
TIME OF ADMISSION: 1823

CHIEF COMPLAINT:
#1. ``I blew up at home''.
#2. Sniffing gas.

HISTORY OF PRESENT ILLNESS: The patient is a 13-year-old white male with a rather long complex psychiatric history including ADHD, OCD, bipolar disorder who was discharged from Concord Hospital on the 28th after being treated for the above symptoms. Patient also has a history of epilepsy and is on Valproic acid and Dilantin for this. Over the last three weeks, the patient has been having more violent behavior and has apparently starting sniffing gas and other volatile chemicals at home. The huffing and sniffing started last July, but has gotten acutely worse in the last two weeks. He otherwise denies any suicidal or homicidal behavior. There is no chest pain, no shortness of breath, no nausea or vomiting, and no abdominal pain. He does have a history of physically abusive behavior for which he was admitted to Concern Hospital. There is no history of physical abuse to his mother at this time. His mother did give him some Ativan and Klonopin prior to coming to the hospital today.

PAST MEDICAL HISTORY is remarkable for:
#1. As above.
#2. Epilepsy.
#3. Cough and asthma.
#4. Chronic sinusitis.
#5. Prosthetic left eye.

PAST SURGICAL HISTORY:
#1. As above, and status post adenoidectomy.

SOCIAL HISTORY: Lives with his Mom.

MEDICATIONS LIST was reviewed.

**ALLERGIES are to Codeine and Demerol which makes him ``wired''.**

REVIEW OF SYSTEMS are as above. He denies any one-sided numbness or tingling. Denies any headache. Denies any shortness of breath or cough. He denies ingesting any drugs or doing anything other than sniffing or huffing volatile chemicals.

Continued.....

**EXETER HOSPITAL, INC.**
Exeter, New Hampshire 03833

Emergency Department Note

RE: IRISH, JOHNATHON
DATE OF SERVICE: 05/08/99

HISTORY OF PRESENT ILLNESS: This young man suffers from asthma, and also from seizure disorders, attention deficient disorder, obsessive compulsive disorder, and is bipolar. He hasn't been feeling well all week. He was diagnosed with mononucleosis by Dr. Fiescher in Dover on the 21st of this month. His mother took him down to Boston to an allergist yesterday who said that he has sinusitis and put him on some antibiotics, apparently Zithromax, and the child has had really decreased appetite and is not taking fluids very well, and has been coughing, coughing, coughing which is usually his expression of his asthma.

His MEDICINES include Zithromax, Topamax, Depakote, Clomipramine, Accolate, Clonidine, and antihistamine Allegra.

He is allergic to codeine and Demerol.

On PHYSICAL EXAMINATION: He is a husky 12-year-old boy in no acute distress. Coughing continuously. Temperature 90, pulse 91, respirations 20, blood pressure 99/57. He weighs 121 pounds. His O2 saturation is 99%. His ear canals are clear. Tympanic membranes are not injected. Oropharynx is benign. Neck is soft and supple with no palpable nodes. The lungs have good breath sounds and are clear. Heart - regular rate and rhythm without no murmurs, clicks, or heaves. He does cough non-stop.

I offered respiratory treatment and Mom said that really they just wanted to get some Prelone because the respiratory treatments don't generally help him, and he doesn't like them, and the Prelone helps.

The DIAGNOSIS is acute exacerbation of asthma.

PLAN: They were given a prescription for Prelone syrup, and then the pharmacy called and said that Mom really didn't want liquids. She wanted pills, so she didn't really want Prelone, she wanted prednisone. So it was changed to prednisone tablets 20 milligrams 2 tablets a day for ten days, so a total of 20 tablets. She is to give fluids hourly. If not taking fluids, they should return for IV fluids. They should continue with his other medications and return for any other problem. They should see Dr. Deranian in three or four days.

John Tuohey, A.R.N.P.

JTasne:acne:sm2972
dictated: 05/08/99
transcribed: 05/10/99

**EXETER HOSPITAL**
EXETER, NH 03833

EMERGENCY DEPARTMENT NOTE

RE: IRISH, Jonathan
DATE OF SERVICE: 5/22/98

HISTORY OF PRESENT ILLNESS: patient is an 11-year-old male who last night at 6:30 hit his left hand on a door frame and then fell on the floor with pain, swelling, and bruising over the dorsum of the left hand. Since that time no weakness or numbness, no wrist, elbow, or shoulder injury.

PAST MEDICAL HISTORY: asthma; seizures.

CURRENT MEDICATIONS: as per chart.

ALLERGIES: as per chart.

DT: up-to-date.

PHYSICAL EXAMINATION: vital signs stable; patient afebrile.
EXAMINATION OF LEFT HAND: ecchymosis, swelling, and point tenderness over the medial aspect of the dorsum of the left hand, 2nd and 3rd metacarpals. No bony deformity. Capillary refill intact. No rotatory deformity. Distal motor strength 5/5. Full active and passive range of motion of the metacarpophalangeal joints of the left hand.

X-RAYS: rule out ? of non-displaced fracture, proximal left 2nd metacarpal.

DIAGNOSIS: left hand contusion with ? non-displaced left 2nd metacarpal fracture.

PLAN: patient is placed in a splint. Ice. Limited use. Patient's mother is to call for formal x-ray reading tomorrow. Follow up with Dr. King if positive.

Philip J. Voss, M.D.

PV:asne:EHeg2017
dictated: 5/23/98
transcribed: 5/24/98

**EXETER HOSPITAL, INC.**
Exeter, NH 03833

EMERGENCY ROOM REPORT
RE: Irish, Johnathan
DATE OF SERVICE: 4-18-98

SUBJECTIVE: The patient is complaining of left earache and headache since this morning. Mother is quite anxious and concerned because he has a history of ruptured eardrum twice, although she is not sure if it is the left that was involved or not. Denies any recent cold symptoms. No drainage from ears. Denies nasal congestion, rhinorrhea, cough, fever, nausea or vomiting, diarrhea or rash. Also has two small erythematous areas on face, one at right temple, the other on the left cheek. Mother states these may be insect bites or scratches.

PAST MEDICAL HISTORY: Asthma, attention deficit hyperactivity disorder, obsessive/compulsive disease and right eye prosthesis secondary to enucleation from trauma.

CURRENT MEDICATIONS: Accolate, Aleve, Depakote, clonidine, Tegretol, Zoloft, Albuterol inhaler and Azmacort inhaler.

ALLERGIES: CODEINE causes nausea and vomiting, DEMEROL causes hyperactivity.

OBJECTIVE: Alert, oriented, 11 year old male in no acute distress with flat affect who does not always answer examiner's questions until prompted to by mother. Vital signs - temperature 96.9, pulse 75, respirations 20, blood pressure 98/72, oxygen saturation 98%.
SKIN: Small erythematous non-edematous areas, one just lateral to right eye, one on left cheek, neither show signs of infection.
HEENT: Head - normocephalic. No facial tenderness. Eyes - extraocular movements intact, pupils equal, react right and left to light and accommodation. Nares patent. Left ear - tympanic membrane shows signs of old healed rupture, clear with good light reflex, no erythema. External auditory canal - erythematous. No drainage. Right ear - tympanic membrane is clear, external auditory canal non-erythematous. Pharynx - non-erythematous.
NECK: Supple with full range of motion and no masses.
LUNGS: Clear anterior and posterior.
HEART: Regular rate and rhythm.

ASSESSMENT:
1. Left otitis externa.
2. Black fly bites.

**EXETER HOSPITAL, INC.**
**Exeter, NH 03833**

**EMERGENCY ROOM REPORT**

**RE: IRISH, JOHNATHON S.**
**DATE OF SERVICE: 12-09-95**

**HISTORY OF PRESENT ILLNESS:** This is a 9-year-old white male seen in the Emergency Department on 12-09-95 at 18:25 hours.

This patient dropped a metal pipe on his right first toe yesterday and is having pain since that time.

**PAST MEDICAL HISTORY:** He has a history of epilepsy and asthma, chronic sinusitis and ADD. He has no other complaints.

**PHYSICAL EXAMINATION:** Reveals moderate swelling and slight ecchymosis with a small subungual hematoma to the right first toe. He has full flexion, extension, actively and passively with some pain. His x-ray shows a fracture to the distal phalanx, right first toe.

**PLAN:** The patient does not want his subungual hematoma relieved with a cautery. He has had his first and second toes taped together. He is to keep them taped for three weeks and may change the tape as needed. He is to walk as tolerated. He is to apply ice and elevation for swelling, use Tylenol for pain; return if there are any problems.

**DIAGNOSIS:** Fractured right first toe.

DAVID HELLER, D.O.

DH/asne/ehlbh41
Dictated: 12-09-95
Transcribed: 12-11-95

**EXETER HOSPITAL, INC.**
Exeter, N.H. 03833

**EMERGENCY DEPARTMENT NOTE**

RE: IRISH, JONATHAN
DATE OF SERVICE: 3/18/95

HISTORY: The patient is an 8 year-old white male who presents complaining of an itchy rash on his face, initially on his left cheek, and then has generalized to involve face, scalp, and behind the right ear, as well as the anterior chest. Denies any difficulty swallowing, breathing or wheezing. Denies any other complaints at this time. No known allergen contacts except for a dog at home and a possible history of exposure to a neighborhood dog. The patient does have known allergies to dog dander. No new medications or other new allergens. Formally allergy tested 4 years ago.

PAST MEDICAL HISTORY: Asthma and seizure disorder.

CURRENT MEDICATIONS: Depakote and Vancenase.

ALLERGIES: CODEINE and DEMEROL.

PHYSICAL EXAMINATION: Vital signs stable. Patient afebrile. A well developed, well nourished white male in no acute distress, itching the rash.
HEENT: throat without oropharyngeal angioedema. Mucous membranes moist. No erythema. Maxillofacial area with areas of macular erythematous rash without vesicles, pruritic in nature.
NECK: supple, no adenopathy.
HEART: regular rate and rhythm without murmur.
LUNGS: clear to auscultation. No wheezes.

DIAGNOSIS:
1. Facial contact dermatitis.

PLAN: As per chart.

**EMERGENCY DEPARTMENT NOTE**

IRISH, JONATHAN VOSS 413777

**EXETER HOSPITAL, INC.**
Exeter, NH 03833

EMERGENCY DEPARTMENT NOTE

RE: IRISH, JOHNATHON
DATE OF SERVICE: 10/16/94

HISTORY: This is an 8 year old white male seen in the Emergency Department on 10/16/94 at 19:37 hours. This patient has not felt well since yesterday. He has had some frontal headaches and some mid abdominal pain off and on since that time. His appetite has been good, however. He has had a sore throat. He has had a slight dry cough and runny nose and he had some intermittent earache mostly to the right ear yesterday that is gone today. He has had nausea without vomiting or diarrhea. He has had no wheezing. He has a history of asthma. He has a history of hyper-activity and seizures. This patient also had adenoid surgery and sinus surgery three weeks ago by Dr. Yeganeh.

PHYSICAL EXAMINATION: Reveals a patient whose temperature is 98.9. Skin turgor is good. Mucous membranes moist. There is no rash. The ears are bilaterally injected over the tympanic membranes. The nose has moderate nasal congestion with slight tenderness over the frontal and maxillary sinuses. The throat has a post nasal drip, but no tonsilar enlargement or exudate with minimal redness. The neck is supple with no lymphadenopathy or meningeal signs. Lungs are clear. Heart regular rate and rhythm without murmur. Abdomen is soft with no significant tenderness, rebound or guarding.

PLAN: The patient is given Amoxicillin 250 mg. to take three times a day for ten full days. Tylenol for pain and fever. Return if there are any problems. Follow up with his own doctor in fourteen to 21 days for a recheck.

DIAGNOSIS: Bilateral otitis media.

DH:asne:LF109
dictated: 10/16/94
transcribed: 10/18/94

DAVID HELLER, D.O.

EMERGENCY DEPARTMENT NOTE

IRISH, JOHNATHON ER HELLER/FISHER/YEGANEH 413777

**EXETER HOSPITAL, INC.**
**Exeter, N.H. 03833**

EMERGENCY DEPARTMENT RECORD
MEDICAL RECORD #: 413777
DATE OF SERVICE: 11/19/93

The patient is a seven year old white male who presents stating that his mother noted him to be complaining of a pruritic rash that initially started on his back and then generalized to his chest and lower extremities. The patient denies any chest pain, shortness of breath, wheezing. He denies any known allergen contact. The patient states that he had school project recently where he was working and handling rats and guinea pigs. The patient also has had problems with flea bites in the home in the past, status post having the home sprayed. The patient denies any other complaints at this time.

PAST MEDICAL HISTORY: Asthma.

CURRENT MEDICATIONS: As per chart.

ALLERGIES: Per chart.

PHYSICAL EXAMINATION: VITAL SIGNS: Stable. The patient is afebrile. SKIN exam reveals multiple discrete macular circular erythematous rashes involving the back, trunk and lower extremities, pruritic in nature. No vesicles. HEART: Regular rate and rhythm. LUNGS: Clear to auscultation.

DIAGNOSIS: Insect bite versus viral exanthem

Philip J. Voss, MD

PJV:ASNE:DB 304
Dictated: 11/20/93
Transcribed: 11/21/93

**EMERGENCY ROOM REPORT**

IRISH, Jonathan DOB: Voss 413777

**EXETER HOSPITAL, INC.**
Exeter, NH 03833

EMERGENCY DEPARTMENT REPORT
RE: 413777
DATE OF SERVICE: 10/3/93

This is a seven year old male with a history of asthma who presents to the Emergency Department with episode of barking cough and choking at home. The child has been well until this afternoon when his symptoms began quite suddenly. The patient also has a history of epilepsy and has apparently had a seizure in the past when he developed acute bronchospasm.

CURRENT MEDICATIONS include Proventil inhaler and nebulizer as well as Azmacort nasal inhaler.

PHYSICAL EXAMINATION: VITAL SIGNS: Recorded. Young white male, alert, cooperative who appears to be in no acute distress. He is moving air quite well. His 02 saturation is 100%. His LUNGS reveal a few scattered wheezes, no rales or rhonchi. There is no stridor present. Pharynx and oropharynx are benign. The child is noted to have a barking cough.

EMERGENCY ROOM COURSE: The child was treated with albuterol, .5 cc and 3 ccs of normal saline and cool mist therapy.

IMPRESSION: Laryngotracheitis.

PLAN: The patient will be started on Prelone. He is to follow up with his family physician or to return to the Emergency Room if worse. The patient is in stable and improved on discharge with no visible respiratory distress whatsoever.

RICHARD GILSTON, M.D.

RG/asne/DB 242
dictated: 10/3/93
transcribed: 10/4/93

Gilston 10/5/93

EMERGENCY ROOM REPORT

IRISH, Jonathan DOB: Gilston 413777

**EXETER HOSPITAL, INC.**
Exeter, NH 03833

EMERGENCY ROOM REPORT
RE: IRISH, ~~Jonathan~~ Johnathon
DATE OF SERVICE: 2-25-93

The patient is a 6 year old white male with a history of asthma who presents with mother stating that he had a persistent non-productive cough for the past several weeks despite initially being treated with Amoxicillin and currently being treated with Erythromycin. The patient also complains of bilateral earache. The patient's mother states that the coughing is worse at night but denies any chest pain or shortness of breath. Denies any fever, chills, nausea, vomiting or diarrhea.

PAST MEDICAL HISTORY: Asthma.

MEDICATIONS: Erythromycin, Vanceril, Proventil, Vancranase, Phenergan with Codeine. Allergies to Demerol and "Codeine".

PHYSICAL EXAMINATION reveals vital signs stable. The patient is afebrile. A well developed thin white male in no acute distress. Throat with erythema or exudate. Mucous membranes moist.Uvula midline. TM's clear. Neck supple. No adenopathy. Heart regular rate and rhythm. Lungs clear to auscultation in all fields. The abdomen reveals positive bowel sounds, soft and non-tender with no rebound or guarding.

Chest X-ray no acute distress. Pulse oxymetry 99% on room air.

After a long discussion with the patient, and mother it was elected to follow-up with Dr. Windt and he has an appointment for the early part of next week. Continue current medications as above. Return if condition worsens.

DIAGNOSIS: Asthma and URI.

PHILIP VOSS, M.D.

PV/asne/sjm-2279
dictated: 2-26-93
transcribed: 2-28-93

EMERGENCY DEPARTMENT NOTE

IRISH, ~~Jonathan~~ Johnathon Voss 413777

**EXETER HOSPITAL, INC.**
Exeter, NH 03833

EMERGENCY DEPARTMENT REPORT
RE: Irish, Johnathon S.
DATE OF SERVICE: 2-13-93

HISTORY: This is a 6 year old male seen in the Emergency Department on 2-13-93 at 12:41 hours. This patient has had a cough for 1 1/2 weeks with some phlegm. He has had a slight fever. No chills. He has had an earache for 1 1/2 weeks and a headache as well as sore throat. No vomiting or diarrhea. He did see Dr. Dibble three or four days ago and was started on amoxicillin as well as asthma medicines. He has had no wheezing, but he has had no improvement since that time either.

PHYSICAL EXAMINATION reveals a patient who has a nontoxic appearance. Skin turgor is good. Mucous membranes are moist. There is no evidence of any respiratory difficulty whatsoever. There is no rash.

EARS: Not injected or retracted.
NOSE: Slight clear discharge.
THROAT: Unremarkable.
NECK: Supple with no lymphadenopathy or meningeal signs.
LUNGS: Clear with no adventitious sounds.
HEART: Regular rhythm without murmur.
ABDOMEN: Soft and nontender.

PLAN: Patient's mother is advised that this is most likely one of the viral symptoms that is prevalent in the area. He should continue all medications, but he may not improve for another week or two. Humidifier in the room may help. He should return or see a doctor if symptoms worsen.

DIAGNOSIS:
1. Upper respiratory infection.

DH/asne/kd
dictated: 2-13-93
transcribed: 2-15-93

DAVID HELLER, D.O.

**EMERGENCY ROOM REPORT**

**IRISH, JOHNATHON S.** **HELLER/DIBBLE 413777**